



## California State Athletic Commission

1424 Howe Ave. Ste. #33

Sacramento, CA 95825

www.dca.ca.gov/csac/

(916) 263-2195 FAX (916) 263-2197

**APPLICATION FOR AMATEUR ATHLETE****BOXING****KICKBOXING**

Your application will be considered "Pending" if any information is not completed.

<p>One (1) passport sized photograph (2"x 2").</p> <p>Physical Examination Report by licensed physician.</p>	<p style="text-align: center;"><b>OFFICE USE ONLY</b></p> <p>Date of Application: _____</p> <p>Date License Approved: _____</p> <p>License # and Exp. Date: _____</p> <p>P/E Exp. Date: _____</p>																
<p><b>Section 1. Please print the following information:</b></p> <table style="width: 100%;"> <tr> <td style="width: 33%;">Last</td> <td style="width: 33%;">First</td> <td style="width: 33%;">Middle</td> <td style="width: 33%;"><b>Social Security Number:</b></td> </tr> <tr> <td colspan="4">Address:</td> </tr> <tr> <td>Street (No PO BOX)</td> <td>City</td> <td>State</td> <td>Zip Code Country</td> </tr> <tr> <td colspan="4">Telephone number:</td> </tr> </table>		Last	First	Middle	<b>Social Security Number:</b>	Address:				Street (No PO BOX)	City	State	Zip Code Country	Telephone number:			
Last	First	Middle	<b>Social Security Number:</b>														
Address:																	
Street (No PO BOX)	City	State	Zip Code Country														
Telephone number:																	
Age:	Male / Female Circle one	Birth Date: (MM / DD / YYYY):	Height: ____ Ft. ____ In.	Weight: _____ pounds													
<p><b>Section 2. Please print the following information:</b></p> <p>Have you ever used any other name(s)?    YES    NO If yes, list name(s): _____</p> <p>Have you ever been disqualified in any competition?    YES    NO If yes, please explain: _____</p> <p>_____</p>																	
<p><b>Section 3.</b> Amateur boxing record:</p> <p>Wins: _____ Wins by KO/TKO: _____ Losses: _____</p> <p>Losses by KO/TKO: _____</p>			<p><b>Section 4.</b> Amateur martial arts record:</p> <p>Wins: _____ Wins by KO/TKO/Submissions: _____</p> <p>Losses: _____ Losses by KO/TKO/Submissions: _____</p>														

Revised December 2007

## APPLICATION FOR AMATEUR ATHLETE

APPLICANT NAME: \_\_\_\_\_

### Section 5. Please print the following information:

If you are now or have ever been licensed by the California State Athletic Commission, another athletic commission, or any similar governmental authority, provide the following information for each license, listing the most recent first:

TYPE OF LICENSE	LICENSE YEAR	STATE/OTHER COMMISSION/ GOVERNMENTAL AUTHORITY
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your license ever been suspended, revoked or fined by the California State Athletic Commission, another athletic commission or any similar governmental authority? **YES** **NO** If YES, provide the following information:

TYPE OF LICENSE	ACTION TAKEN	REASON FOR ACTION	DATE OF ACTION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there charges pending against you by the California State Athletic Commission, another athletic commission or any similar governmental authority? **YES** **NO** If YES, provide the following information:

OFFENSE	DATE OF OFFENSE	GOVERNMENTAL AUTHORITY	HEARING DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you been convicted of a crime in the past 10 years? **YES** **NO** If YES, provide the following information:

OFFENSE	DATE OF CONVICTION	CITY, STATE, COUNTRY	SENTENCE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there any charges pending against you by any law enforcement agency? **YES** **NO** If YES, provide the following information:

OFFENSE	DATE OF OFFENSE	CITY, STATE, COUNTRY	HEARING OR TRIAL DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Revised December 2007

## APPLICATION FOR AMATEUR ATHLETE

APPLICANT NAME: \_\_\_\_\_

### Section 6. Please Print the Following Information:

#### EMERGENCY CONTACT INFORMATION:

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Phone Number \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Country \_\_\_\_\_

## PLEASE READ CAREFULLY

### AUTHORIZATION TO RELEASE INFORMATION

Authority to provide the California State Athletic Commission with this information is established pursuant to Sections 18640, 18642 and 18643 of the Business and Professions Code. Disclosure of your social security number is mandatory pursuant to Section 30 of the Business and Professions Code and Pub. L.94-455 (42 USCA 405 © © authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, and for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code. The social security number is also used to report and credit boxer pension fund payments in implementing Sections 18880, 18881, 18882, 18883, 18884, 18887, and 18888 of the Business and Professions Code. If you fail to disclose your social security number your application for initial or renewal license will not be processed AND you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.

All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure. Information on your application and physical examination report may be released to law enforcement agencies. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Executive Officer is the custodian of records.

### APPLICANT DECLARATION

I declare under penalty of perjury under the laws of the State of California, that I have read the foregoing application for a professional athlete's license and that all the answers given are my own. I further declare that all the answers are true AND THAT THE HIV/HBV/HCV TEST REPORT REPRESENTS MY HIV/HBV/HCV TEST RESULTS. I understand that any misstatement of material fact in this application will constitute grounds for denying or revoking the license.

Applicant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**This item is VOLUNTARY. You do not have to check this box.**

☐ I hereby authorize the California State Athletic Commission to release my telephone number to any commission licensee for contact purposes. This authorization shall be valid during the license year in which this application is signed.

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**AMATEUR ATHLETE PHYSICAL EXAMINATION*****Only a licensed Physician may conduct this examination and complete this form.******Please complete this form in its entirety.*****BOXING****KICKBOXING**
**Office Use**  
 Approved by: \_\_\_\_\_  
 Date: \_\_\_\_\_

<b>Last</b>	<b>First</b>	<b>Middle</b>
<b>Address:</b>		
<b>Street (No PO BOX)</b>	<b>City</b>	<b>State</b>
		<b>Zip Code</b>
<b>Country</b>		
<b>Telephone number:</b>		
<b>Age:</b>	<b>Male / Female</b> Circle one	<b>Birth Date:</b> (MM / DD / YYYY):
<b>PHYSICAL HISTORY: Please check all that applies below:</b> <b>Asthma</b> <b>Blood in urine</b> <b>Allergies</b>  <b>Fainting spells</b> <b>Rupture (hernia)</b> <b>Chest pains</b> <b>Operations</b> <b>Shortness of breath</b> <b>Swollen joints</b>  <b>Rheumatism</b> <b>Diabetes</b> <b>Frequent headaches</b> <b>Convulsions (fits)</b> <b>Chronic cough</b> <b>Spitting of blood</b>  <b>Cerebral hemorrhage or serious head injury</b> If yes, please explain: _____		
<b>When was the last time you took any type of medication or drug? (State what type and when and be specific):</b> _____ _____		
<b>Have you ever undergone any type of surgery?    Yes    No (State what type and when and be specific):</b> _____		
<b>When was the last time you took any type of vitamin supplement? (State what type and when and be specific):</b> _____ _____		
<b>Amateur boxing record:</b>  Wins: _____ Wins by KO/TKO: _____ Losses: _____  Losses by KO/TKO: _____	<b>Amateur martial arts record:</b>  Wins: _____ Wins by KO/TKO/Submissions: _____  Losses: _____ Losses by KO/TKO/Submissions: _____	

**Revised December 2007**

# AMATEUR ATHLETE PHYSICAL EXAMINATION

APPLICANT NAME: \_\_\_\_\_

## PHYSICAL EXAMINATION:

General appearance: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Temperature: \_\_\_\_\_ Disabling scars: \_\_\_\_\_ Mouth: \_\_\_\_\_ Teeth: \_\_\_\_\_ Tonsils: \_\_\_\_\_  
Neck: \_\_\_\_\_ Pulse at rest: \_\_\_\_\_ Pulse after 100 hops: \_\_\_\_\_ Blood pressure: At  
rest: \_\_\_\_\_ After 100 hops: \_\_\_\_\_ 2 minutes later: \_\_\_\_\_  
Enlarged glands: Yes No – Goiter: Yes No – Heart: Pulse rhythm Regular Irregular –  
Murmurs: Yes No – Musculoskeletal system: \_\_\_\_\_  
Apical impulse: Heavy Normal - Enlargement: Yes No – Lungs: Rales Yes No  
Abdomen: Enlargement of liver Yes No – Breasts: Mass Yes No – Tenderness Yes No –  
Discharge Yes No – Enlargement of Spleen: Yes No – Hernia: Yes No –  
Testicles: Normal Yes No  
Remarks: \_\_\_\_\_

Reflexes: Pupils \_\_\_\_\_ Knee jerks \_\_\_\_\_ Romberg \_\_\_\_\_ Babinski \_\_\_\_\_  
Skin: Tone \_\_\_\_\_ Rash \_\_\_\_\_ Boils \_\_\_\_\_ Other: \_\_\_\_\_  
Unhealed wounds: \_\_\_\_\_  
Remarks: \_\_\_\_\_

## EYE HISTORY: Have you ever had any of the following conditions:

Blurred vision? Yes No – If YES, please explain in full: \_\_\_\_\_

Have you ever had any surgical procedures done to your eye(s) or the tissues around your eye(s) other than simple sutures of the skin around the eye?

Yes No – If YES, please explain in full: \_\_\_\_\_

Have you ever been diagnosed by a physician to have significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, or dislocated lens? Yes No – If YES, please explain in full: \_\_\_\_\_

## EYE EXAMINATION:

Vision without glasses Right \_\_\_\_\_ Left \_\_\_\_\_

Vision with glasses Right \_\_\_\_\_ Left \_\_\_\_\_

Visual fields Right \_\_\_\_\_ Left \_\_\_\_\_

## EXAMINING PHYSICIAN:

Based on your personal observation and review of the test results and considering Commission rules, is it your medical opinion that this applicant is physically fit to be licensed and compete in combative sports? **Yes No**

If no, please explain: \_\_\_\_\_

LICENSED PHYSICIAN'S NAME (print) \_\_\_\_\_ MEDICAL LICENSE NO. \_\_\_\_\_ APPLICANT NAME (print) \_\_\_\_\_

ADDRESS / CITY / STATE / ZIP CODE \_\_\_\_\_ APPLICANT SIGNATURE \_\_\_\_\_

TELEPHONE NO. \_\_\_\_\_ DATE/TIME \_\_\_\_\_ PERSON WHO ASSISTED'S NAME (print) \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_ PERSON WHO ASSISTED'S SIGNATURE \_\_\_\_\_